WESTON, (E.B.)

A new procedure in case of anticipated complete rupture of the perineum.

A NEW PROCEDURE IN CASES OF ANTICIPATED COMPLETE RUPTURE OF THE PERINEUM.*

BY

EDWARD B. WESTON, A. M., M. D.

Fellow of the American Academy of Medicine; Fellow of the Chicago Gynæcological Society: Member of the Medico-Legal Society of Chicago; Surgeon to the Chicago, St. Paul & Kansas City Railway; etc.

On the fourth day of last month I was, for the fourth time, called to attend Mrs. H. in labor. She is a woman somewhat below the average size and has a rather narrow pelvis; while her children are all large at birth.

At the birth of her first child, a boy who weighed twelve pounds, she received a complete laceration of the perineum. The second child, also a boy, weighed nine and one-half pounds, and the perineum was torn to the anal sphincter. The third pregnancy was terminated in the sixth month, by unknown cause. The child was of course small, but delivery took place very rapidly and there was again a rupture, though not to the same degree as in the second labor.

On visiting the patient at the beginning of her last labor an examination showed a well restored perineum, and a child seemingly very large, presenting in the first position.

Meditating over the situation, remembering what had taken place in her previous labors, I feared a complete rupture would again occur, however well I might apply the various methods or procedures for protecting the perineum. The thought came to me that it would be well to introduce a

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deep suture before the laceration occurred, and before the head began to press upon the perineum, so that if complete rupture did take place I should have one suture already in place, by means of which I could easily bring the parts into accurate apposition, and which could in a measure be used as forceps or tenaculum, and be of great service in whatever after-operation might be necessary. I could see no objection to the step; so with a long curved needle I introduced a silk suture a little more than half an inch to the right of the anus and carried it up about an inch and a half in the recto-vaginal septum and brought it out on the left side at a point corresponding to its point of entrance. I left either end six inches long and tied them together.

Again there was a laceration, though not a complete one. The child, a boy, weighed eleven pounds.

Objections will, of course, be raised to the procedure which I have suggested. Let us consider a few of them.

One objection will be that we cannot tell when we are to have a complete rupture. We cannot always know in advance, and here the unexpected often happens. But in some cases we feel very sure it will occur, and it is in these cases that the stitch should be introduced. And in cases of doubt the stitch had better be placed, as it will in any event do no harm. Another objection may be, that if rupture should take place we cannot tell what direction it will take. In the great majority of cases, externally the laceration occurs practically in the median line. So that whatever its internal course may be, all the advantages claimed for the stitch will be obtained.

Again: that should the procedure be recognized as proper in certain rare cases, it will be abused by too frequent use. And, that with the stitch in place, and confidence in the future assistance to be derived from it, our vigilance in protecting the perineum might be relaxed.

To these objections we can only say that the conscientious accoucheur would not be influenced by them.

Some will suggest the danger of sepsis. We do not believe this need be feared. If antiseptic precautions have been observed and the stitch buried in the tissues through its whole length, the increased danger will be *nil.* If, fortunately, rupture does not occur, the stitch can be cut short at one side, withdrawn, and no injury have been done. Others will say that,

even should complete rupture take place, the physician should be skillful enough to repair it by some one of the old methods. This is true; but the fact remains that there are all degrees of surgical skill, ranging from no skill, to that of the highest degree.

It may also be said that the obstetrician who would introduce the stitch before laceration occurred would be the very one who would have the least need of it afterwards. We grant it. But the majority would prefer to have the stitch in place, rather than to begin repairs without it; the parts being not only lacerated but often so contused, swollen or retracted that their normal relations can scarcely be made out.

If, by the procedure suggested, some one may be enabled to repair a complete laceration of the perineum, which otherwise would be left for a gynæcologist to repair after the patient had suffered, mentally as well as physically, for weeks or months, we think it cannot be objected to. And however expert an operator may be it is true that the easiest, simplest way of obtaining a desired result from operative procedure is the best way.

These are the chief objections which have occurred to us as likely to be raised. The advantages of the procedure have already been sufficiently indicated.

3225 Vernon Avenue, Chicago.